		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039347

Facility Name: Montgomery Nursing and Rehabilitation Center

Address: South Route 127, P.O. Box 309 (Number) Hillsboro (City) 62049 (Zip Code)

County: Montgomery

Telephone Number: (217) 532-6126 **Fax #** (217) 532-9465

IDPA ID Number: 37-1323740

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	21	Skilled (SNF)	21	7,665	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,200	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,464	1,981	3,019	8,464	8
9	SNF/PED					9
10	ICF	13,192	7,545		20,737	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,656	9,526	3,019	29,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.21%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 4/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 4/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 16 and days of care provided 3,019

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Cen # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	155,560	10,492	5,566	171,618		171,618		171,618			1
2	Food Purchase		134,698		134,698		134,698	(444)	134,254			2
3	Housekeeping	78,160	11,037		89,197		89,197		89,197			3
4	Laundry	53,806	9,299		63,105		63,105		63,105			4
5	Heat and Other Utilities			84,382	84,382		84,382	586	84,968			5
6	Maintenance	43,447	5,890	28,960	78,297	135	78,432	785	79,217			6
7	Other (specify):* Waste Removal			5,091	5,091		5,091		5,091			7
8	**TOTAL General Services**	330,973	171,416	123,999	626,388	135	626,523	927	627,450			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	959,093	49,460	8,267	1,016,820	(2,065)	1,014,755	(454)	1,014,301			10
10a	Therapy		573	201,446	202,019		202,019	(13,898)	188,121			10a
11	Activities	41,473	3,905	831	46,209		46,209		46,209			11
12	Social Services	27,953	217	1,184	29,354		29,354		29,354			12
13	Nurse Aide Training					2,811	2,811	(451)	2,360			13
14	Program Transportation		2,430		2,430		2,430		2,430			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,028,519	56,585	221,328	1,306,432	746	1,307,178	(14,803)	1,292,375			16
	C. General Administration											
17	Administrative	52,485	3,241	155,860	211,586	(426)	211,160	(75,480)	135,680			17
18	Directors Fees											18
19	Professional Services			39,818	39,818		39,818	10,607	50,425			19
20	Dues, Fees, Subscriptions & Promotions			32,982	32,982	(666)	32,316	(21,221)	11,095			20
21	Clerical & General Office Expenses	58,556	12,249	60,145	130,950		130,950	17,813	148,763			21
22	Employee Benefits & Payroll Taxes			253,314	253,314	211	253,525	11,505	265,030			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,116	5,116		5,116	3,648	8,764			24
25	Other Admin. Staff Transportation							4,544	4,544			25
26	Insurance-Prop.Liab.Malpractice			46,274	46,274		46,274	3,906	50,180			26
27	Other (specify):*											27
28	**TOTAL General Administration**	111,041	15,490	593,509	720,040	(881)	719,159	(44,678)	674,481			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,470,533	243,491	938,836	2,652,860		2,652,860	(58,554)	2,594,306			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center #0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			104,504	104,504		104,504	3,212	107,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			216,798	216,798		216,798	(23,358)	193,440			32
33	Real Estate Taxes			32,222	32,222		32,222	591	32,813			33
34	Rent-Facility & Grounds							4,065	4,065			34
35	Rent-Equipment & Vehicles			838	838		838	1,794	2,632			35
36	Other (specify):* Mortgage Ins.			11,800	11,800		11,800		11,800			36
37	TOTAL Ownership			366,162	366,162		366,162	(13,696)	352,466			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,996	1,996		1,996		1,996			38
39	Ancillary Service Centers		67,170	23,779	90,949		90,949	(484)	90,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		67,170	81,072	148,242		148,242	(484)	147,758			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,470,533	310,661	1,386,070	3,167,264		3,167,264	(72,734)	3,094,530			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(444)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,829)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(685)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,419)	24		19
20	Contributions	(345)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,125)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,955)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,802)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(43,932)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (43,932)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (72,734)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Montgomery Nursing and Rehabilitation Center

ID# 0039347

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate PAC & Lobbying Dues	$ (2,170)	20	1
2	To add 2003 IDPH License Paid in 2002	200	20	2
3	Offset Medicare Billing Income from Other Home	(1,150)	21	3
4	Offset Lab Refunds Received	(484)	39	4
5	Offset CNA Class Reimbursements Received	(901)	13	5
6	Offset Medical Supply Rebates/Reimbursements	(454)	10	6
7	Eliminate Non-care Related Travel	(446)	24	7
8	To Add Expense for 2003 CNA Exams Paid in 2004	450	13	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,955)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center **#** 0039347 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(444)	0	0	0	0	0	0	0	0	0	0	(444)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	586	0	0	0	0	0	0	0	0	0	586	5
6	Maintenance	0	785	0	0	0	0	0	0	0	0	0	785	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(444)	1,371	0	0	0	0	0	0	0	0	0	927	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(454)	0	0	0	0	0	0	0	0	0	0	(454)	10
10a	Therapy	0	0	(13,898)	0	0	0	0	0	0	0	0	(13,898)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(451)	0	0	0	0	0	0	0	0	0	0	(451)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(905)	0	(13,898)	0	0	0	0	0	0	0	0	(14,803)	16
	C. General Administration													
17	Administrative	0	80,380	(155,860)	0	0	0	0	0	0	0	0	(75,480)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,019	8,588	0	0	0	0	0	0	0	0	10,607	19
20	Fees, Subscriptions & Promotions	(22,125)	904	0	0	0	0	0	0	0	0	0	(21,221)	20
21	Clerical & General Office Expenses	(1,150)	18,963	0	0	0	0	0	0	0	0	0	17,813	21
22	Employee Benefits & Payroll Taxes	0	11,505	0	0	0	0	0	0	0	0	0	11,505	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,865)	5,513	0	0	0	0	0	0	0	0	0	3,648	24
25	Other Admin. Staff Transportation	0	4,544	0	0	0	0	0	0	0	0	0	4,544	25
26	Insurance-Prop.Liab.Malpractice	0	3,906	0	0	0	0	0	0	0	0	0	3,906	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(25,140)	127,734	(147,272)	0	0	0	0	0	0	0	0	(44,678)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,489)	129,105	(161,170)	0	0	0	0	0	0	0	0	(58,554)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	3,212	0	0	0	0	0	0	0	0	0	3,212	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,829)	47	(21,576)	0	0	0	0	0	0	0	0	(23,358)	32
33	Real Estate Taxes	0	591	0	0	0	0	0	0	0	0	0	591	33
34	Rent-Facility & Grounds	0	0	4,065	0	0	0	0	0	0	0	0	4,065	34
35	Rent-Equipment & Vehicles	0	0	1,794	0	0	0	0	0	0	0	0	1,794	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,829)	3,850	(15,717)	0	0	0	0	0	0	0	0	(13,696)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(484)	0	0	0	0	0	0	0	0	0	0	(484)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(484)	0	0	0	0	0	0	0	0	0	0	(484)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,802)	132,955	(176,887)	0	0	0	0	0	0	0	0	(72,734)	45

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Jerseyville Nursing and Rehabilitation Ctr, Inc.	Jerseyville, IL	Wellington Mgmt Co	Chesterfield, MO	Management Co
David L. Kamler	10.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co
J. Terry Dooling	10.00	Spanish Lake Nursing and Rehabilitation Center	Florissant, MO	C.J. Schlosser & Co.	Alton, IL	Public Accountants
R.J. Tolliver	10.00			NW Rehab, L.L.C.	Alton, IL	Therapy Co
Jack A. Yeager	10.00			Three Amigos, LLC	Alton, IL	Real Estate Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Wellington Management Co	60.00%	$ 586	$ 586	1
2	V	6	See Schedule VIII		Wellington Management Co	60.00%	785	785	2
3	V	17	See Schedule VIII		Wellington Management Co	60.00%	80,380	80,380	3
4	V	19	See Schedule VIII		Wellington Management Co	60.00%	2,019	2,019	4
5	V	20	See Schedule VIII		Wellington Management Co	60.00%	904	904	5
6	V	21	See Schedule VIII		Wellington Management Co	60.00%	18,963	18,963	6
7	V	22	See Schedule VIII		Wellington Management Co	60.00%	11,505	11,505	7
8	V	24	See Schedule VIII		Wellington Management Co	60.00%	5,513	5,513	8
9	V	25	See Schedule VIII		Wellington Management Co	60.00%	4,544	4,544	9
10	V	26	See Schedule VIII		Wellington Management Co	60.00%	3,906	3,906	10
11	V	30	See Schedule VIII		Wellington Management Co	60.00%	3,212	3,212	11
12	V	32	See Schedule VIII		Wellington Management Co	60.00%	47	47	12
13	V	33	See Schedule VIII		Wellington Management Co	60.00%	591	591	13
14	Total			$			$ 132,955	$ * 132,955	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 4,065	$ 4,065	15
16	V	35	See Schedule VIII		Wellington Management Co.	60.00%	1,794	1,794	16
17	V	17	Management Fees	112,219	Wellington Management Co.	60.00%		(112,219)	17
18	V	17	Management Fees	43,641	Health Care Financial, LLC	40.00%		(43,641)	18
19	V	19	Professional Services	32,365	CJ Schlosser & Company, LLC	40.00%	40,953	8,588	19
20	V	10a	Therapy Services	201,446	NW Rehab, LLC	100.00%	187,548	(13,898)	20
21	V	32	Interest	7,600	Health Care Financial, LLC	40.00%	2,803	(4,797)	21
22	V	32	Interest	16,779	John H. Rothert	60.00%		(16,779)	22
23	V	10	Nursing & Medical Records	5,954	Wellington Management Co.	60.00%	5,954		23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 420,004			$ 243,117	$ * (176,887)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ce # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	John H. Rothert	President	Administrative	60.00	189,620	9.35	23.00	Salary	$ 57,828	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 57,828		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Wellington Management Company
Street Address: 750 Spirit 40 Park Drive
City / State / Zip Code: Chesterfield, MO 63005
Phone Number: (636) 537-8447
Fax Number: (636) 537-8446

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	11,968,251	5	$ 2,509	$	2,796,968	$ 586	1
2	6	Maintenance	Accumulated Costs	11,968,251	5	3,361		2,796,968	785	2
3	17	Administrative	Accumulated Costs	11,968,251	5	343,945	343,945	2,796,968	80,380	3
4	19	Professional Services	Accumulated Costs	11,968,251	5	8,641		2,796,968	2,019	4
5	20	Dues, Fees, Subscriptions and Pro	Accumulated Costs	11,968,251	5	3,868		2,796,968	904	5
6	21	Clerical and General Office Exp	Accumulated Costs	11,968,251	5	81,144	34,438	2,796,968	18,963	6
7	22	Employee Benefits and PR Taxes	Accumulated Costs	11,968,251	5	49,230		2,796,968	11,505	7
8	24	Travel and Seminar	Accumulated Costs	11,968,251	5	23,590		2,796,968	5,513	8
9	25	Other Admin Staff Transport	Accumulated Costs	11,968,251	5	19,444		2,796,968	4,544	9
10	26	Insurance - Prop., Liab.,Malprac	Accumulated Costs	11,968,251	5	16,713		2,796,968	3,906	10
11	30	Depreciation	Accumulated Costs	11,968,251	5	13,746		2,796,968	3,212	11
12	32	Interest	Accumulated Costs	11,968,251	5	202		2,796,968	47	12
13	33	Real Estate Taxes	Accumulated Costs	11,968,251	5	2,530		2,796,968	591	13
14	34	Rent-Facility & Ground	Accumulated Costs	11,968,251	5	17,395		2,796,968	4,065	14
15	35	Rent-Equipment & Vehicles	Accumulated Costs	11,968,251	5	7,677		2,796,968	1,794	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 593,995	$ 378,383		$ 138,814	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Cen # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial Mortgage		X	Refinance Mortgage	$17,016.17	9/29/99	$ 2,415,500	$ 2,350,640	10/1/34	7.9200	$ 186,921	1
2												2
3								Loan Cost Amortization			4,663	3
4								Home Office Allocation			47	4
5								Interest Income			(1,829)	5
	Working Capital											
6	Health Care Financial, LLC	X		Working Capital	N/A	9/1/97	80,000	80,000	9/1/07	9.5000	2,803	6
7	First National Bank		X	Line of Credit	N/A	1/4/03	100,000	1	1/4/04	Prime + 1%	835	7
8												8
9	TOTAL Facility Related				$17,016.17		$ 2,595,500	$ 2,430,641			$ 193,440	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,595,500	$ 2,430,641			$ 193,440	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 11,800** **Line # 36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	31,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,722	2
3. Under or (over) accrual (line 2 minus line 1).	$	222	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	32,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	32,222	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	26,955	8
	1999	28,716	9
	2000	30,459	10
	2001	31,369	11
	2002	31,722	12

Line 2: 2002 Taxes Paid

Line 4: Accrual is based on 2002 Taxes Paid.

Line 7: $32,222 + $591 (Home Office R.E. Tax Allocation) = $32,813 Total R.E. Taxes-Schedule V, Line 33, Col 8

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nursing and Rehabilitation Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0039347

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE 618-465-7717 FAX #: 618-465-7710

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-100-716-75	NE PT SE SW Land Corp Limit	$ 31,722.30	$ 31,722.30
2.		Taylor Springs	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,722.30	$ 31,722.30

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,192 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	348,480	1994	$ 27,673	1
2					2
3	TOTALS	348,480		$ 27,673	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		$ 962,086	$ 38,483	25	$ 38,483	$	$ 375,214	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shed			1994	3,247	325	10	325		3,084	9
10	Air Conditioner			1994	76,140	7614	10	7,614		72,333	10
11	Cabinets			1994	6,809	340	20	340		3,149	11
12	Doors			1994	2,337	117	20	117		1,090	12
13	Electrical			1994	4,601	230	20	230		2,104	13
14	Flooring			1994	25,850	2585	10	2,585		24,102	14
15	Exterior Remodeling			1994	4,468	298	15	298		2,780	15
16	Interior Remodeling			1994	66,214	4428	15	4,428		40,549	16
17	Nurse Call System			1994	1,960	131	15	131		1,209	17
18	Plumbing			1994	6,619	331	20	331		3,053	18
19	Roof			1994	29,619	2962	10	2,962		27,889	19
20	Window/Gutters			1994	60,254	4017	15	4,017		37,826	20
21	Siding			1994	15,818	1055	15	1,055		9,565	21
22	Landscaping			1994	3,134	313	10	313		2,951	22
23	Parking Lot			1994	29,107	2911	10	2,911		27,568	23
24	Home Office Wallpapering/Flooring			1994	3,695		5			3,695	24
25	Flooring			1995	938	94	10	94		844	25
26	Metal Doors and Frames			1996	953	48	20	48		357	26
27	Metal Carport			1997	972	65	15	65		405	27
28	Carpet			1997	2,310		5			2,310	28
29	Dining Room Chair Rail			1997	2,230	149	15	149		892	29
30	Wallpapering			1997	4,830		5			4,830	30
31	Fire Doors			1997	593	30	20	30		178	31
32	Foliage & Fountains			1997	1,657	166	10	166		1,118	32
33	Interior Painting			1997	514		5			514	33
34	Shed			1997	315	31	10	31		192	34
35	Door Alarm System			1997	7,840	784	10	784		4,770	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sidewalk Replacement	1997	$ 650	$ 43	15	$ 43	$	$ 264	37
38	Beauty Shop Remodeling	1998	4,287	214	20	214		1,125	38
39	Wallpapering	1998	1,493	76	5	76		1,493	39
40	Shower Room Remodeling	1998	1,199	60	20	60		320	40
41	Mini Blinds Installed	1998	509	51	10	51		300	41
42	Shelving	1998	566	28	20	28		153	42
43	Baseboard Remodeling	1998	820	82	10	82		486	43
44	Water Heater	1998	6,040	403	15	403		2,114	44
45	Folding Doors	1998	456	46	10	46		239	45
46	Door Installed	1998	208	21	10	21		108	46
47	Wall Mounted Laundry Tub	1998	181	9	20	9		54	47
48	Shower Flooring	1998	401	40	10	40		204	48
49	Shed	1998	185	19	10	19		94	49
50	Flooring	1998	293	29	10	29		159	50
51	Air Conditioning Unit	2000	557	56	10	56		200	51
52	Asphalt Parking Lot	2000	2,360	236	10	236		787	52
53	Fire Doors	2001	1,534	102	15	102		264	53
54	Signage	2001	3,318	664	5	664		1,714	54
55	Cove Base	2001	1,006	101	10	101		258	55
56	Window Treatments	2001	7,272	1,454	5	1,454		3,757	56
57	Wallpapering	2001	37,693	7,539	5	7,539		19,427	57
58	Lobby Carpet	2001	1,433	286	5	286		764	58
59	Air Conditioner	2001	1,696	170	10	170		424	59
60	Home Office Wallpapering	1999	621		5	124	124	601	60
61	Cove Base	2002	604	60	10	60		71	61
62	Wallpapering	2002	4,462	892	5	892		1,554	62
63	Air Conditioner	2002	1,981	198	10	198		330	63
64	Blinds	2002	512	102	5	102		196	64
65	Flooring & Cave Base	2002	1,630	163	10	163		312	65
66	Wall Guard	2002	1,927	128	15	128		236	66
67	Fire Doors	2002	1,042	69	15	69		104	67
68	AC/Heat Pump Units	2002	1,580	158	10	158		224	68
69	Home Office Light Fixtures	2002	225		10	22	22	43	69
70	TOTAL (lines 4 thru 69)		$ 1,413,851	$ 81,006		$ 81,152	$ 146	$ 692,950	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,413,851	$ 81,006		$ 81,152	$ 146	$ 692,950	1
2	Air Conditioners	2003	3,110	118	10	118		118	2
3	11 Fire Doors	2003	5,950	99	15	99		99	3
4	Home Office Cabinets	2003	976		10	49	49	49	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,423,887	$ 81,223		$ 81,418	$ 195	$ 693,216	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 177,563	$ 19,090	$ 20,219	$ 1,129	5-20	$ 70,169	71
72	Current Year Purchases	5,277	429	515	86	5-10	515	72
73	Fully Depreciated Assets	287,262	1,865	2,275	410	5-7	287,262	73
74								74
75	TOTALS	$ 470,102	$ 21,384	$ 23,009	$ 1,625		$ 357,946	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1997 Minivan	2000	$ 7,589	$ 1,897	$ 1,897	$	4	$ 6,166	76
77	Home Office - Admin	2000 Taurus	2000	5,566		1,392	1,392	4	4,638	77
78										78
79										79
80	TOTALS			$ 13,155	$ 1,897	$ 3,289	$ 1,392		$ 10,804	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,934,817	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,504	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,716	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,212	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,061,966	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [N/A] YES [N/A] NO

16. Rental Amount for movable equipment: $ 838 Description: Ice Machine $802, Gas Tank $36
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		1,882		1,882
6	Transportation				
7	Contractual Payments		263		263
8	Nurse Aide Competency Tests		215		215
9	TOTALS	$	$ 2,360	$	$ 2,360
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,360			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,8	2686 hrs	$ 77,551		$	$	2,686	$ 77,551	1
2	Licensed Speech and Language Development Therapist	10a,8	1319 hrs	45,308				1,319	45,308	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	2589 hrs	64,689			573	2,589	65,262	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				67,170		67,170	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory Fees Other (specify): X-Rays	39,3 39,3				18,123 5,656			18,123 5,656	13
14	TOTAL			$ 187,548		$ 23,779	$ 67,743	6,594	$ 279,070	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 74,547	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	503,938		3
4	Supply Inventory (priced at cost)	12,726		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,855		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	10,179		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 613,245	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	30,300		12
13	Land	62,924		13
14	Buildings, at Historical Cost	1,383,119		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	462,077		16
17	Accumulated Depreciation (book methods)	(1,041,832)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	36,161		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	143,406		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,076,155	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,689,400	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 454,355	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1		29
30	Accrued Salaries Payable	58,162		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,809		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Uniforms Payable	448		36
37	Due to Related Parties	312,850		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 876,625	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	192,792		39
40	Mortgage Payable	2,350,640		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,543,432	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,420,057	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,730,657)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,689,400	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,665,789)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,665,789)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(64,868)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (64,868)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,730,657)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,131,551	1
2	Discounts and Allowances for all Levels	(444,005)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,687,546	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	393,722	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 393,722	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,549	12
13	Barber and Beauty Care	97	13
14	Non-Patient Meals	444	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,853	19
20	Radiology and X-Ray	2,862	20
21	Other Medical Services		21
22	Laundry	153	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,958	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,829	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,829	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,341	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,341	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,102,396	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	626,388	31
32	Health Care	1,306,432	32
33	General Administration	720,040	33
	B. Capital Expense		
34	Ownership	366,162	34
	C. Ancillary Expense		
35	Special Cost Centers	92,945	35
36	Provider Participation Fee	55,297	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,167,264	40
41	**Income before Income Taxes (line 30 minus line 40)****	(64,868)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (64,868)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Filed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,458	1,531	$ 35,516	$ 23.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,552	7,613	137,821	18.10	3
4	Licensed Practical Nurses	14,888	15,775	229,376	14.54	4
5	Nurse Aides & Orderlies	59,105	61,936	526,683	8.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,464	4,659	41,473	8.90	10
11	Social Service Workers	1,877	2,138	27,953	13.07	11
12	Dietician					12
13	Food Service Supervisor	1,739	2,019	24,096	11.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,228	19,290	131,464	6.82	15
16	Dishwashers					16
17	Maintenance Workers	4,206	4,514	43,447	9.62	17
18	Housekeepers	10,209	11,129	78,160	7.02	18
19	Laundry	8,999	9,386	53,806	5.73	19
20	Administrator	2,228	2,228	52,485	23.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,901	4,321	58,556	13.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,377	2,466	29,697	12.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,231	149,005	$ 1,470,533 *	$ 9.87	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	117	$ 5,566	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	16	718	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,132	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	831	11,3	44
45	Social Service Consultant	19	1,184	12,3	45
46	Other(specify) Advisory Board	N/A	200	10,3	46
47	Quality Assurance Nurse	N/A	5,954	10,3	47
48					48
49	TOTAL (lines 35 - 48)	166	$ 25,185		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	Section N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Carla Vonder Harr	Administrator	0.00	52,485
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,485

B. Administrative - Other

Description	Amount
Wellington Management Company - Management Fees	$ 112,219
Health Care Financial, L.L.C. - Management Fees	43,641
TOTAL (agree to Schedule V, line 17, col. 3)	$ 155,860
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, L.L.C.	Accounting Services	$ 32,365
Hughes & Associates, CPA	Audit Fees	5,141
Ted Frapolli	Legal Services	104
McMahon, Berger, Hanna, et al	Legal Services	2,208
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 39,818

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,583
Unemployment Compensation Insurance	28,647
FICA Taxes	111,657
Employee Health Insurance	22,839
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Relations	4,251
Employee Disability Insurance	471
Employee Dental Insurance	2,077
Home Office Employee Benefits	11,505
TOTAL (agree to Schedule V, line 22, col.8)	$ 265,030

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,395
Health Care Worker Background Check	
(Indicate # of checks performed 82)	984
Dues, Subscriptions & Manuals	2,144
Licenses & Fees	445
Bank Service Charge	1,735
IHCA Dues	3,288
Home Office Dues, Fees & Subscriptions	904
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,095

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,274
Seminar Expense	1,977
Home Office Travel and Seminar	5,513
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,764

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Section Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $3,288**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **454** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **No**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,297**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **444**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **27.58%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **None**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Hughes & Associates** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not Yet Complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/03

DESCRIPTION	LINE #	INCREASE (DECREASE)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(666)
NURSE AIDE TRAINING	13	666
To reclass expenses for CNA class books to proper line		
ADMINISTRATIVE	17	(426)
MAINTENANCE	6	135
NURSING & MEDICAL RECORDS	10	80
EMPLOYEE BENEFITS & PAYROLL TAXES	22	211
To reclass maintenance supplies & dental visits to proper line		
NURSE AIDE TRAINING	13	263
NURSING & MEDICAL RECORDS	10	(263)
To reclass CNA class evaluator to proper line		
NURSE AIDE TRAINING	13	1,882
NURSING & MEDICAL RECORDS	10	(1,882)
To reclass CNA trainer wages		

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/03

Cable Income	28
Medicare Billing Income	1,150
Seniorcise Program Income	1,230
Lab Refunds from Hillsboro Area Hospital	484
CNA Class Reimbursements	901
Med Supply Reimbursements/Rebates	454
Other Miscellaneous Income	94
	4,341

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2003

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST	SEMINAR LODGING/ TRAVEL/MEALS
Carla Vonder Haar	Administrator	5/19/2003	Springfield, IL	Conference on Alzheimer Disease & Related Disorders	SIU School of Medicine	50	
Stacy Payne	DON	5/19/2003	Springfield, IL	Conference on Alzheimer Disease & Related Disorders	SIU School of Medicine	50	
Tammy Richmond	Social Services	5/19/2003	Springfield, IL	Conference on Alzheimer Disease & Related Disorders	SIU School of Medicine	50	
Birdie Scroggins	Activities	4/3/2003	Fairview Heights, IL	Beyond the Basics: Achieving Excellence in Activities	Outcome Services of Illinois	65	
Sherrie Gutierez	Activities	4/3/2003	Fairview Heights, IL	Beyond the Basics: Achieving Excellence in Activities	Outcome Services of Illinois	65	
Carla Vonder Haar	Administrator	3/17/2003	Springfield, IL	Illinois' New Medicaid Reimbursement System	Illinois Health Care Association	150	
Mindy Pearse	MDS Coordinator	3/17/2003	Springfield, IL	Illinois' New Medicaid Reimbursement System	Illinois Health Care Association	150	
Carla Vonder Haar	Administrator	7/30/2003	Springfield, IL	Implementing Illinois' New Medicaid Reimbursement System	Life Services Network	90	
Mindy Pearse	MDS Coordinator	7/30/2003	Springfield, IL	Implementing Illinois' New Medicaid Reimbursement System	Life Services Network	75	
Lisa Carroll	RN	9/22-9/26/03	Springfield, IL	CNA Instructor Course	Lincoln Land Community College	315	
Stacey Roach	RN	11/10-11/12/03	Springfield, IL	IV Therapy for Nurses	Lincoln Land Community College	215	
Candy Jones	CNA	11/19-11/21/03	Springfield, IL	Occupational Rehab Aide Training Program	Lincoln Land Community College	200	
Birdie Scroggins	Activities	10/23-10/24/03	Peoria, IL	2003 IAPA Convention	IAPA	165	292
Various	Various	11/6/2002	Hillsboro, IL	CPR Class	Montgomery County CPR Instructors Assoc.	20	
Various	Various	11/21/2003	Hillsboro, IL	Infection Control	Angela Tefteller, RN	25	
						1685	292
					Total Seminar Lodging/Travel/Meals	292	
					Other Travel Expense <$250	1274	
					Home Office Travel & Seminar	5513	
					Total Travel & Seminar, Line 24	8764	